Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS BACK INSTITUTE
PO BOX 262409
PLANO TX 75026-2409

Respondent Name
LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-06-1330-01

MFDR Date Received
October 19, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The procedure performed was a Charite artificial disk. A CPT code has not been assigned to this procedure and a miscellaneous code was used to report the service performed. This procedure is equivalent to an anterior lumbar interbody fusion. Those codes, with work comp fees, are as follows:

One Level		Two Level	
63090.62	$711.00	63090.62	$711.00
62558	$1881.06	63091.62	$151.31
22851	$563.15	22558	$1881.06
20931	$154.54	22585	$463.91
		22851 X 2	$563.15 X 2
		20931	$154.54"

Amount in Dispute: $674.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We believe the relative value for the procedure, CPT 63077 is a more appropriate code to use to determine fair and reasonable. . . . Medicare uses CPT 22214 . . . The code we used for comparison has a higher relative value unit that the one Medicare uses. . . . Reimbursement was not made for CPT20931, as this if for an allograft for spine surgery structural, which is not reflected in the operative report."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2005	CPT Code 22899	$674.77	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 19, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 31, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z560 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE. (Z560)
   - P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - PA – FIRST HEALTH

Findings

1. The insurance carrier reduced payment for the disputed service with reason codes P303 – "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)" and PA – "FIRST HEALTH." The requestor's position statement asserts "We have not been contracted with First Health since 11/1/04." Review of the submitted information finds no documentation to support that the disputed service is subject to a contract between the parties to this dispute. The insurance carrier's reduction reasons are not supported. The dispute will therefore be reviewed per applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.202(c)(1), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Medicare does not establish a relative value unit or payment amount for procedure code 22899, therefore the appropriate rule for determining reimbursement of this services is 28 Texas Administrative Code §134.1(c).
3. This dispute relates to professional services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration." Review of the submitted documentation finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
6. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the submitted documentation finds that the request does not include a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B).
7. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not discuss how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).

8. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
9. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor asserts that "This procedure is equivalent to an anterior lumbar interbody fusion. Those codes, with work comp fees, are as follows:

One Level		Two Level	
63090.62	$711.00	63090.62	$711.00
62558	$1881.06	63091.62	$151.31
22851	$563.15	22558	$1881.06
20931	$154.54	22585	$463.91
		22851 X 2	$563.15 X 2
		20931	$154.54"

   - The requestor did not specify which of the two methodologies should be used to calculate reimbursement; however, review of the submitted operative report finds that the surgery was performed only on one level. Therefore, the requestor's "One Level" calculation will be deemed as the requestor's proposed reimbursement methodology for the service in this dispute.
   - The respondent's position statement asserts that "We also believe that fair and reasonable reimbursement is equivalent to the reimbursement made for an anterior lumbar fusion, for one level. We calculated the fair and reasonable reimbursement based on these following codes: CPT 63077 . . . CPT 22558-62 . . . CPT 22845 . . . Reimbursement was not made for CPT20931, as this if for an allograft for spine surgery structural, which is not reflected in the operative report."
   - The respondent further asserts that "The provider did not take into consideration the TX WCFS and Medicare Rules for multiple surgical procedure reductions."
   - While both parties agree that the disputed service performed is equivalent to an anterior lumbar fusion for the purpose of determining fair and reasonable reimbursement, the parties do not agree as to which procedure codes best represent the services included in an anterior lumbar fusion.
   - The requestor has the burden of proof by a preponderance of the evidence to support that the proposed reimbursement is fair and reasonable.
   - The requestor did not submit documentation to support what services or procedure codes comprise an anterior lumbar fusion.
   - The requestor did not submit documentation to support the Medicare reimbursement calculation for the proposed procedure codes.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 13, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.